XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
DAVID CARR
Deputy Attorney General
State Bar No. 131672
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3380
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GUIDO JAMES GORES, JR., M.D.** 909 Hyde St., Suite 125 San Francisco, CA 94109-4832 Physician's and Surgeon's Certificate No. G 61254, Respondent.	Case No. 800-2017-032089 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 8, 1987, the Medical Board issued Physician's and Surgeon's Certificate Number G 61254 to Guido James Gores, Jr., M.D. (Respondent). The Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

8. Section 4022 of the Code defines "dangerous drug" to include any drug unsafe for self-use and includes all drugs which can only be lawfully dispensed by prescription.

9. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. The acts alleged herein occurred in California.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient One)

11. Respondent is subject to disciplinary action in that his care and treatment of Patient One[1] includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

12. Patient One's first documented office visit with Respondent occurred on January 6, 2010. Patient One told Respondent that he had just moved to California and was seeking continuing care for chronic back pain consequent to a fall, for which he had been receiving oxymorphone[2] and carisoprodol[3], and for his Attention Deficit Disorder, for which he had been

[1] The patients discussed herein are referred to as Patient One through Patient Five to preserve patient confidentiality. The patients' full names will be provided to Respondent upon request.

[2] Oxymorphone hydrochloride (trade name Opana) is a semi-synthetic opioid analgesic. Oxymorphone hydrochloride a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxymorphone hydrocloride has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other central nervous system depressant drugs during treatment.

[3] Carisoprodol is a muscle-relaxant and sedative. It is a dangerous drug as defined in

taking Adderall.[4] Respondent's chart notes reflect that he prescribed oxycodone[5] to Patient One at this initial office visit, rather than the previously-prescribed oxymorphone, at the patient's request.

13. Over the course of the next two years, Respondent regularly re-prescribed opiates (oxycodone and oxycontin[6]) and carisopridol for Patient One's chronic pain and Adderall for the patient's Attention Deficit Disorder. There is no documentation in Respondent's records of his care of Patient One that Respondent performed a focused examination of the patient's back in evaluating the patient's chronic back pain.

14. Respondent's last office visit with Patient One occurred on May 7, 2012. At that visit, Respondent charted that Patient One was complaining of neck pain in addition to the continuing complaint of back pain. Respondent's chart entries note an unremarkable visit aside from examining Patient One's neck in response to the new neck pain complaint and noting the chronic back pain. After two years of continual prescribing of opiates for Patient One's chronic back pain, Respondent did not refer Patient One to a chronic pain specialist or spine specialist. After prescribing Adderall consistently to Patient One for two years for the patient's claimed Attention Deficit Disorder, Respondent did not refer Patient One to a psychiatrist for clinical assessment and treatment of this psychological condition. Respondent refilled Patient One's prescriptions for Adderall at a dosage level of 92 mg. per day, for carisoprodol, and for 200 tablets of oxycodone 30 mg, which averages as a daily dose of 300 morphine milligram.

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section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

[4] Adderall, a trade name for mixed amphetamine salts, is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055 of the Health and Safety Code.

[5] Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

[6] Oxycontin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone is a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Respiratory depression is the chief hazard from all opioid medications.

equivalent (MME). A review of prescribing records reveals that Patient One was being concurrently prescribed opiates by other prescribers as well in this same time period. There is no indication in Respondent's medical records that he made inquiry as to whether Patient One was being prescribed opiates or other controlled substances by any other care provider concurrently with Respondent's prescribing, nor any documentation that Respondent attempted to coordinate his prescribing and care with any other provider.

15. On May 23, 2012, Patient One was seen at a critical care hospital emergency department for shortness of breath; he was found to be suffering from a streptococcus infection. Toxicology tests were positive for amphetamine, heroin, cannabinoids, and opiates. He was admitted to the intensive care unit for treatment but developed multiple organ failure and died on May 25, 2012. A post-mortem report listed Patient One's cause of death as "acute mixed drug intoxication..." and septic complications.

16. Respondent is subject to disciplinary action in that his failure--after two years of prescribing carisoprodol, Adderall, and high doses of opiates in combination--to have referred Patient One to a specialist in chronic pain and to a psychiatrist for Attention Deficit Disorder was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/ Repeated Negligence—Patient One)

17. The allegations of paragraphs 12 through 15 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing of high doses of narcotic medication, in combination with carisoprodol and high doses of Adderall, for a prolonged period to Patient One was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records—Patient One)

18. The allegations of paragraphs 12 through 15 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to maintain adequate and accurate medical records of his care and treatment of Patient One constitutes unprofessional conduct by application of section 2266.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient One)

19. The allegations of paragraphs 12 through 15 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to effectively monitor Patient One's use of prescribed opiates and Adderall by periodic toxicology screening was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Two)

20. Respondent is subject to disciplinary action in that his care and treatment of Patient Two includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

21. Respondent first saw Patient Two at an initial office visit on March 17, 2015, for a primary complaint of left hip pain. Patient Two stated that he was scheduled for a left hip replacement within the coming months; his right hip had been successfully replaced some years earlier. Patient Two stated also that he had been seen the prior month in a local critical care emergency room for an apparent seizure. Patient Two related that he had a history of seizures which he stated had been attributed to alcohol withdrawal. Respondent ordered lab tests and conducted a physical examination which did not include an examination of Patient Two's hip. To

address the patient's complaint of hip pain, Respondent prescribed hydrocodone[7] for Patient Two at this office visit.

22. Patient Two returned on April 10, 2015. He informed Respondent that he was scheduled for a left hip replacement in May; Patient Two reported that he now needed ten hydrocodone tablets daily for the pain. Respondent discussed risks and side effects of narcotics with Patient Two. Respondent then switched Patient Two's pain prescription from hydrocodone to oxycodone.

23. At the next office visit on April 28, 2015, Respondent conducted a pre-operative clearance examination on Patient Two and deemed him eligible for the hip-replacement surgery. Respondent referred Patient Two to a neurologist for consultation regarding the February seizure episode. At this visit Respondent also increased Patient Two's oxycodone daily dose by 50%. Respondent did not see Patient Two or prescribe for him for the following eleven months.

24. Respondent's chart notes indicate the next office visit with Patient Two occurred on April 18, 2016. Patient Two was requesting a pre-surgical examination for a procedure on his left ear scheduled for later that month. Patient Two also complained of periodic anxiety, for which he requested medication. Respondent performed the pre-surgery examination and pronounced Patient Two fit for surgery; Respondent also prescribed alprazolam[8] to be taken as needed for anxiety, along with the continuing prescription for oxycodone. There is a passing reference indicating that the patient has had both hips replaced, but no documentation that Respondent inquired about the most recent hip surgery's effect and whether it would allow a decrease in the amount of pain medication Respondent was prescribing.

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[7] Hydrocodone is a semisynthetic narcotic analgesic compounded with acetaminophen; it is a dangerous drug as defined in section 4022 and a Schedule III controlled substance as defined by section 11056, subdivision (e) of the Health and Safety Code. Prolonged use of hydrocodone may result in psychological and physical dependence.

[8] Alprazolam (trade name Xanax) is a medication of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

25. At the next office visit on June 28, 2016, Respondent noted that Patient Two may be suffering from bipolar disorder or attention deficit disorder and that he was reportedly seeing a therapist. Patient Two also stated that the oxycodone prescribed was effectively controlling his pain. Respondent refilled the prescription to Patient Two for alprazolam and oxycodone.

26. When Patient Two returned to Respondent's office on August 24, 2016, he informed Respondent he was seeing a psychiatrist. Respondent contacted the psychiatrist and it was agreed among the three that the psychiatrist, and not Respondent, would prescribe the alprazolam or other anti-anxiety medication to Patient Two. At an office visit just two weeks later, on September 7, 2016, Patient Two told Respondent that he had terminated his treatment with the psychiatrist because the psychiatrist recommended that no benzodiazepines be prescribed to Patient Two. Nonetheless, Respondent agreed to prescribe the benzodiazepine (alprazolam) Patient Two was requesting. Respondent also discussed Patient Two's complaint of possible attention deficit disorder and began a trial of Adderall to address the symptoms Patient Two described.

27. At subsequent office visits over the next nine months, Respondent's chart entries note that Patient Two was doing well on the Adderall and alprazolam. Respondent regularly re-filled Patient Two's prescriptions for both medications, as well as the prescription for oxycodone; Respondent stated in an interview with Board investigators that Patient Two was an avid surfer who sometimes injured himself and frequently required pain medication.

28. Respondent's chart entry for the office visit on June 9, 2017, notes a discussion with the patient regarding a telephone call Respondent received from one of Patient Two's family members, in which the family member voiced concerns with Patient Two's use of the medications he was receiving. Respondent recorded Patient Two's reply as attributing the family member's concerns to Patient Two's behavioral and mood issues primarily related to alcohol use; Patient Two told Respondent that he was not presently using alcohol and intended to refrain from doing so in the future. A separate treatment record dated July 9, 2017, found in Respondent's medical records, described emergency care provided to Patient Two for sudden onset of neck pain and arm numbness at a local critical care hospital emergency department, notes that Patient Two was

currently using alcohol. Respondent continued to prescribe alprazolam, Adderall, and oxycodone for Patient Two through February of 2018.

29. Respondent is subject to disciplinary action against his license for unprofessional conduct, in that his failure to effectively monitor the patient's use of a prescribed opiate, a benzodiazepine, and Adderall by periodic toxicology screening, when Respondent was aware of Patient Two's prior, and possibly contemporaneous, alcohol abuse, was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Two)

30. The allegations of paragraphs 21 through 28 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing of narcotic medication, in combination with the benzodiazepine alprazolam and the amphetamine Adderall for a prolonged period to Patient Two, when Respondent was aware of Patient Two's history of alcohol abuse and of the specific concerns presented by Patient Two's family member, was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Three)

31. Respondent is subject to disciplinary action in that his care and treatment of Patient Three includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

32. Respondent had been treating Patient Three since approximately 1999 for a number of conditions, including HIV, hepatitis C, and depression. Patient Three had long-standing complaints of multiple sources of pain; Respondent had prescribed hydrocodone for Patient

Three's pain since 2008. Patient Three also informed Respondent that he had a history of amphetamine abuse.

33. At the office visit on June 4, 2012, Patient Three complained of pain in his hips, thighs, and ankles. Respondent ordered an MRI to evaluate for possible neurogenic claudication and continued his prescription of hydrocodone for Patient Three's pain. At the July 6, 2012 office visit Respondent discussed the MRI results showing Patient Three's severe spinal disc disease; Patient Three rejected Respondent's recommendations that he see a spine specialist and to commence physical therapy. Respondent continued the hydrocodone he was prescribing for Patient Three's pain, and substituted Adderall for the prior amphetamine Patient Three had been receiving from his psychiatrist for symptoms of attention deficit disorder.

34. Respondent's chart notes from the office visit on October 3, 2012, indicate that Patient Three told Respondent his pain was inadequately controlled and that he had tried his neighbor's morphine tablets, with greater effect. Respondent prescribed percocet[9] and one month later began a trial of controlled-release morphine[10] to accompany the hydrocodone already being prescribed to Patient Three. Respondent also continued the Adderall he was now regularly prescribing to Patient Three, ostensibly due to the patient's inability to secure continuing psychiatric care for his attention deficit disorder. At the office visit on February 4, 2013, Patient Three requested refills of his prescriptions for morphine and Adderall and requested a new prescription for oxycontin; Respondent provided these medications as requested.

35. On June 4, 2013, Patient Three was hospitalized with multiple stroke symptoms, including garbled speech and tingling bilaterally. Diagnostic imaging showed a small infarct in the brain, indicative of a stroke. The hospital record, included in Respondent's medical record,

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[9] Percocet, a trade name for a combination of oxycodone hydrochloride and acetaminophen, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine, a dangerous drug as defined in section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)(N) of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

[10] Morphine sulfate is a potent opioid analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022, a schedule II controlled substance and a narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code.

also contains emergency department notes describing Patient Three's illicit use of methamphetamine.

36. Patient Three saw Respondent next on July 4, 2013. Respondent discontinued the prescription for amphetamine, but continued his prescriptions to Patient Three for oxycodone and controlled-release morphine. At the office visit on November 8, 2013, Respondent declined to prescribe amphetamine as Patient Three was requesting, explaining that amphetamine could increase Patient Three's risk of recurrent stroke. On December 10, 2013, Patient Three told Respondent he would obtain amphetamine on the street if Respondent wouldn't prescribe it for him. Respondent stated in his interview with Board investigators that he believed that prescription amphetamine was safer than Patient Three's obtaining drugs on the street, so he prescribed amphetamine to Patient Three on this visit.

37. On December 28, 2013, emergency personnel were summoned and Patient Three was admitted to hospital care for diagnoses of pneumonia, sepsis, and myocardial infarction. Despite critical care treatment, Patient Three died soon thereafter.

38. Respondent is subject to disciplinary action against his license for unprofessional conduct, in that his failure to effectively refer Patient Three for a psychiatric consultation while prescribing amphetamines to a patient Respondent knew had a history of amphetamine abuse was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Three)

39. The allegations of paragraphs 32 through 37 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to effectively monitor Patient Three's use of prescribed opiates and amphetamine by periodic toxicology screening, most especially in a patient with an admitted history of amphetamine abuse and who had used controlled substances prescribed to others, was a departure from the standard

of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Three)

40. The allegations of paragraphs 32 through 37 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing amphetamine to Patient Three knowing the patient had suffered a recent stroke was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

TENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Four)

41. Respondent is subject to disciplinary action in that his care and treatment of Patient Four includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

42. Respondent first saw Patient Four at an initial office visit on March 30, 2011. Patient Four presented with a complaint of back pain stemming from a lumbar injury with subsequent surgery. Respondent charted a physical exam but no mention is made of a focused examination of Patient Four's back. Respondent continued the patient's pain prescription for oxycodone and alprazolam for the patient's anxiety. Respondent continued this prescribing regimen, with the average morphine milligram equivalent of the oxycodone prescribed of over 500 mg. per day, for the next two and one-half years.

43. At an office visit on May 15, 2012, Respondent documents that the patient's pain is well-controlled on the prescribed medications, oxycodone and alprazolam. Respondent's chart notes state that the patient was reluctant to do additional clinical work-up of his back pain and that he was very busy as a cinematographer. After more than two years of refilling this same opiate and benzodiazepine prescription, Respondent had not referred Patient Four to a spine or

chronic pain specialist for his pain, nor to a psychiatrist for his purported anxiety. The patient returned approximately every other month over the next 15 months for office visits, at which time his prescriptions for both oxycodone and alprazolam were regularly re-filled. Respondent's records do not reflect any updated physical examinations of Patient Four's back or other clinically-significant information relating the pain for which Respondent was prescribing opiates over a two-year period.

44. Patient Four's last visit with Respondent occurred on August 19, 2013. Respondent refilled Patient Four's prescriptions for oxycodone and alprazolam, but noted that he discussed with Patient Four the need for more frequent office visits "considering his pain regimen." Patient Four was also given a copy of Respondent's pain prescribing contract, which he was directed to complete and return. Patient Four died the next day, August 20, 2013. The cause of death was indicated to be accidental acute mixed drug intoxication.

45. Respondent is subject to disciplinary action against his license for unprofessional conduct, in that his failure to effectively refer Patient Four to a psychiatrist for consultation regarding his complaint of anxiety and to a spine or chronic pain specialist for the patient's lumbar spine pain, for which conditions Respondent prescribed alprazolam and oxycodone over the course of two and one-half years, was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Four)

46. The allegations of paragraphs 42 through 44 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to effectively monitor Patient Four's use of prescribed opiate and benzodiazepine by periodic toxicology screening was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

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TWELFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Four)

47. The allegations of paragraphs 42 through 44 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing of very high doses of an opiate to Patient Four, in combination with a benzodiazepine, was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

THIRTEENTH CAUSE FOR DISCIPLINE

(Failure to Keep Adequate Medical Records—Patient Four)

48. The allegations of paragraphs 42 through 44 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to maintain adequate and accurate medical records of his care and treatment of Patient Four constitutes unprofessional conduct by application of section 2266.

FOURTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Five)

49. Respondent is subject to disciplinary action in that his care and treatment of Patient Five includes departures from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c). The circumstances are as follows:

50. Patient Five's initial visit with Respondent was on June 4, 2014. Patient Five was reportedly seeking a new physician to treat his long-term pain, which had ben diagnosed as pudendal neuropathy. The patient stated his pain was not adequately controlled by the oxycodone and gabapentin[11] he had been prescribed by his prior treating physician. Respondent noted Patient Five's related history of depression and alcohol abuse, requested that Patient Five

[11] Gabapentin (trade name Neurontin) is an antiepileptic indicated as adjunctive therapy in the treatment of partial seizures with and without secondary generalization in adults with epilepsy. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

review a pain contract and obtain his prior medical records, and asked Patient Five to return in one week.

51. At the next office visit on June 13, 2014, Respondent noted the patient's contention that his current prescription for 90 mg. of oxycodone per day was insufficient to control his pain; Respondent increased the oxycodone dose from 90 mg. to 120 mg. per day. A signed pain/prescription contract and informed consent are included in the record of this office visit.

52. On the third office visit with Respondent on June 26, 2014, Patient Five complains that his pain is still not adequately controlled; Respondent added a fentanyl patch[12] and increased the dosage of oxycodone. Patient Five is seen again on June 29, 2014, and a CT scan report showing an enlarged prostate is noted. Respondent referred Patient Five for a urological consult. At the office visit on October 15, 2014, Patient Five informed Respondent he did not wish to undergo the surgery recommended by the urologist. Patient Five also requested an increase in the dosage of his oxycodone, which Respondent then prescribed. Three weeks later Patient Five reported that his oxycodone had been stolen; Respondent wrote a prescription for the remainder of the month's supply of oxycodone.

53. Respondent referred Patient Five for a neuropsychology consult in response to the patient's complaint of memory problems. At the office visit on January 31, 2015, Patient Five told Respondent that he was having additional pain. Respondent planned a work-up of this pain complaint, including an MRI. Respondent noted that Patient Five had increased his daily dose of oxycodone from six tablets to eight; Respondent speculated that Patient Five's memory impairment issue could be related to the medications he was taking. Respondent increased the dose of oxycodone he was prescribing to match Patient Five's recent, self-determined increase in his oxycodone dose.

[12] Fentanyl transdermal system goes by the trade name Duragesic. Fentanyl is an opioid analgesic, and a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055 of the Health and Safety Code. Duragesic is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and requires continuous opioid administration. Duragesic presents a risk of serious or life-threatening hypoventilation. Duragesic can produce drug dependence similar to that produced by morphine and has the potential for abuse.

54. Patient Five's MRI results were included in the medical record of the March 24, 2015, office visit; the report showed impingement in the lumbar 4-5 spine. The patient stated his pain was being adequately controlled at his current dosage of oxycodone and fentanyl. No back examination nor recommendations for addressing the diagnosed lumbar impingement were documented at this visit.

55. A consulting gastroenterologist recommended Patient Five undergo anorectal manometry to additionally diagnose his abdominal pain. Notes from the July 10, 2015, office visit reflect Patient Five's refusal to undergo the procedure. Respondent recommended a consult with a neurological surgeon for Patient Five's lumbar pain; there is no subsequent documentation that such a consult took place. Respondent continued to prescribe oxycodone and fentanyl for Patient Five at monthly intervals.

56. At the May 25, 2016, office visit, Patient Five asked Respondent to prescribe transcranial magnetic stimulation treatment for depression. Although Respondent documented that he informed Patient Five that he was not familiar with this modality of treatment, Respondent wrote Patient Five a prescription for a transcranial magnetic stimulation machine. Respondent did not document a referral for a psychiatric consult prior to, or in conjunction with, the prescription for the transcranial magnetic stimulation device. Respondent continued to prescribe oxycodone and fentanyl to Patient Five at the same high dosage levels without documenting clinical confirmation of the need for prescribing this high level of opioid medications.

57. Respondent is subject to disciplinary action against his license for unprofessional conduct, in that his failure to effectively monitor Patient Five's use of prescribed opiate and benzodiazepine by periodic toxicology screening was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

FIFTEENTH CAUSE FOR DISCIPLINE

(Failure to Keep Adequate Medical Records—Patient Five)

58. The allegations of paragraphs 50 through 56 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his failure to maintain

adequate and accurate medical records of his care and treatment of Patient Five constitutes unprofessional conduct by application of section 2266.

SIXTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Five)

59. The allegations of paragraphs 50 through 56 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing of very high doses of opiates over a period of years was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

SEVENTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligence—Patient Five)

60. The allegations of paragraphs 50 through 56 above are incorporated by reference as if set out in full. Respondent's license is subject to disciplinary action in that his prescribing of a transcranial magnetic stimulation device to Patient Five without adequate knowledge of that modality of treatment and without referring the patient for a consultation with an appropriate specialist was a departure from the standard of care constituting gross negligence in violation of section 2234(b) or, in conjunction with the additional allegations herein, repeated negligent acts in violation of section 2234(c).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 61254, issued to Guido James Gores, Jr., M.D.;

2. Revoking, suspending or denying approval of Guido James Gores, Jr., M.D.'s authority to supervise physician assistants and advanced practice nurses;

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3. Ordering Guido James Gores, Jr., M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:

May 8, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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